§ 1396n. Compliance with State plan and payment provisions

(a) Activities deemed as compliance

A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1396a(a) of this title solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1396d(a)(3) of this title or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) of section 1395x(s) of this title, and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this subchapter or under part A or part B of subchapter XVIII of this chapter; or

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) Waivers to promote cost-effectiveness and efficiency

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s)) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State—

(1) to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this subchapter) in selecting among competing health care plans, if such restriction does not substantially impair access to services of adequate quality where medically necessary,

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards shall be consistent with the requirements of section 1396r–4 of this title and are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1396a(a)(37)(A) of this title.

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title. Subsection (h)(2) shall apply to a waiver under this subsection.

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as ''medical assistance'' under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term ''room and board''

shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). A waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.

(5) For purposes of paragraph (4)(B), the term ''habilitation services''—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as such terms are defined in section 1401 of title 20) which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 730 of title 29.

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to serv-

ices under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a nursing facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(C) In making estimates under paragraph (2)(D) in the case of a waiver to the extent that it applies to individuals with mental retardation or a related condition who are resident in an intermediate care facility for the mentally retarded the participation of which under the State plan is terminated, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals without regard to any such termination.

(8) The State agency administering the plan under this subchapter may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under subchapter V of this chapter in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d) Home and community-based services for elderly

(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as ''medical assistance'' under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term ''room and board'' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection (other than a waiver described in subsection (h)(2)) shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year

periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c) of this section.

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1396b of this title to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this subchapter for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this subchapter for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the ''lesser of 7 percent'' shall be deemed to be a reference to the ''greater of 7 percent''.

(iv) If there is enacted after December 22, 1987, an Act which amends this subchapter whose provisions become effective on or after such date and which results in an increase in the aggregate amount of medical assistance under this subchapter for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(i) The term ''home and community-based services'' includes services described in sections 1396d(a)(7) and 1396d(a)(8) of this title, services described in subsection (c)(4)(B) of this section, services described in paragraph (4), and personal care services.

(ii)(I) Subject to subclause (II), the term ''base year'' means the most recent year (ending before December 22, 1987) for which actual final expenditures under this subchapter have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before December 22, 1987, the term ''base year'' means fiscal year 1989.

(iii) The term ''intermediate care facility services'' does not include services furnished in an institution certified in accordance with section 1396d(d) of this title.

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1316(b) of this title.

(B) Notwithstanding any other provision of this chapter, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e) Waiver for children infected with AIDS or drug dependent at birth

(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as ''medical assistance'' under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 5 years of age who—

(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(ii) have such syndrome, or

(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of subchapter IV of this chapter.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

(4) The provisions of paragraph (6) of subsection (d) of this section shall apply to this subsection in the same manner as it applies to subsection (d) of this section.

(f) Monitor of implementation of waivers; termination of waiver for noncompliance; time limitation for action on requests for plan approval, amendments, or waivers

(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this subchapter submitted by the State pursuant to a provision of this subchapter shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(g) Optional targeted case management services

(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1396a(a)(1) of this title and section 1396a(a)(10)(B) of this title. The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1396a(a)(23) of

this title. A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, or to individuals described in section 1396a(z)(1)(A) of this title and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection:

(A)(i) The term ''case management services'' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

(ii) Such term includes the following:

(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

(aa) Taking client history.

(bb) Identifying the needs of the individual, and completing related documentation.

(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

(III) Referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

(aa) whether services are being furnished in accordance with an individual's care plan;

(bb) whether the services in the care plan are adequate; and

(cc) whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred, including, with respect to the direct delivery of foster care services, services such as (but not limited to) the following:

(I) Research gathering and completion of documentation required by the foster care program.

(II) Assessing adoption placements.

(III) Recruiting or interviewing potential foster care parents.

(IV) Serving legal papers.

(V) Home investigations.

(VI) Providing transportation.

(VII) Administering foster care subsidies.

(VIII) Making placement arrangements.

(B) The term ''targeted case management services'' are case management services that are furnished without regard to the requirements of section 1396a(a)(1) of this title and section 1396a(a)(10)(B) of this title to specific classes of individuals or to individuals who reside in specified areas.

(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not part of the target population specified in the State plan, such contacts—

(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

(4)(A) In accordance with section 1396a(a)(25) of this title, Federal financial participation only is available under this subchapter for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A–87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.

(5) Nothing in this subsection shall be construed as affecting the application of rules with respect to third party liability under programs, or activities carried out under title XXVI of the Public Health Service Act [42 U.S.C. 300ff et seq.] or by the Indian Health Service.

(h) Period of waivers; continuations

(1) No waiver under this section (other than a waiver under subsection (c), (d), or (e), or a waiver described in paragraph (2)) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), or (d), or a waiver under section 1315 of this title, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this subchapter, to extend the waiver.

(B) In this paragraph, the term ''dual eligible individual'' means an individual who is entitled to, or enrolled for, benefits under part A of subchapter XVIII, or enrolled for benefits under part B of subchapter XVIII, and is eligible for medical assistance under the State plan under this subchapter or under a waiver of such plan.

(i) State plan amendment option to provide home and community-based services for elderly and disabled individuals

(1) In general

Subject to the succeeding provisions of this subsection, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based services (within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including room and board) for individuals eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 1397jj(c)(5) of this title), without determining that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, but only if the State meets the following requirements:

(A) Needs-based criteria for eligibility for, and receipt of, home and community-based services

The State establishes needs-based criteria for determining an individual's eligibility under the State plan for medical assistance for such home and community-based services, and if the individual is eligible for such services, the specific home and community-based services that the individual will receive.

(B) Establishment of more stringent needs-based eligibility criteria for institutionalized care

The State establishes needs-based criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded under the State plan or under any waiver of such plan that are more stringent than the needs-based criteria established under subparagraph (A) for determining eligibility for home and community-based services.

(C) Projection of number of individuals to be provided home and community-based services

The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.

(D) Criteria based on individual assessment

(i) In general

The criteria established by the State for purposes of subparagraphs (A) and (B) requires an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities, and such other risk factors as the State determines to be appropriate.

(ii) Adjustment authority

The State plan amendment provides the State with the option to modify the criteria established under subparagraph (A) (without having to obtain prior approval from the Secretary) in the event that the enrollment of individuals eligible for home and community-based services exceeds the projected enrollment submitted for purposes of subparagraph (C), but only if—

(I) the State provides at least 60 days notice to the Secretary and the public of the proposed modification;

(II) the State deems an individual receiving home and community-based services on the basis of the most recent version of the criteria in effect prior to the effective date of the modification to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria; and

(III) after the effective date of such modification, the State, at a minimum, applies the criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an intermediate care facility

for the mentally retarded under the State plan or under any waiver of such plan which applied prior to the application of the more stringent criteria developed under subparagraph (B).

(E) Independent evaluation and assessment

(i) Eligibility determination

The State uses an independent evaluation for making the determinations described in subparagraphs (A) and (B).

(ii) Assessment

In the case of an individual who is determined to be eligible for home and community-based services, the State uses an independent assessment, based on the needs of the individual to—

(I) determine a necessary level of services and supports to be provided, consistent with an individual's physical and mental capacity;

(II) prevent the provision of unnecessary or inappropriate care; and

(III) establish an individualized care plan for the individual in accordance with subparagraph (G).

(F) Assessment

The independent assessment required under subparagraph (E)(ii) shall include the following:

(i) An objective evaluation of an individual's inability to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(ii) A face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for home and community-based services.

(iii) Where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual.

(iv) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(v) An examination of the individual's relevant history, medical records, and care and support needs, guided by best practices and research on effective strategies that result in improved health and quality of life outcomes.

(vi) If the State offers individuals the option to self-direct the purchase of, or control the receipt of, home and community-based service, an evaluation of the ability of the individual or the individual's representative to self-direct the purchase of, or control the receipt of, such services if the individual so elects.

(G) Individualized care plan

(i) In general

In the case of an individual who is determined to be eligible for home and community-based services, the State uses the independent assessment required under subparagraph (E)(ii) to establish a written individualized care plan for the individual.

(ii) Plan requirements

The State ensures that the individualized care plan for an individual—

(I) is developed—

(aa) in consultation with the individual, the individual's treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, where appropriate the individual's family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the necessary home and community-based services to be furnished to the individual (or, if the individual elects to self-direct the purchase of, or control the receipt of, such services, funded for the individual); and

(III) is reviewed at least annually and as needed when there is a significant change in the individual's circumstances.

(iii) State option to offer election for self-directed services

(I) Individual choice

At the option of the State, the State may allow an individual or the individual's representative to elect to receive self-directed home and community-based services in a manner which gives them the most control over such services consistent with the individual's abilities and the requirements of subclauses (II) and (III).

(II) Self-directed services

The term ''self-directed'' means, with respect to the home and community-based services offered under the State plan amendment, such services for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services, under the State plan consistent with the following requirements:

(aa) Assessment

There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(bb) Service plan

Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that satisfies the requirements of subclause (III).

(III) Plan requirements

For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

(aa) specifies those services which the individual or the individual's au-

thorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual's authorized representative will select, manage, and dismiss providers of such services;

(cc) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

(dd) is developed through a person-centered process that is directed by the individual or the individual's authorized representative, builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities, and involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(ee) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities of the individual or the individual's authorized representative; and

(ff) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(IV) Budget process

With respect to individualized budgets described in subclause (III)(ff), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(bb) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(H) Quality assurance; conflict of interest standards

(i) Quality assurance

The State ensures that the provision of home and community-based services meets Federal and State guidelines for quality assurance.

(ii) Conflict of interest standards

The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(I) Redeterminations and appeals

The State allows for at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) Presumptive eligibility for assessment

The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for home and community-based services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (E) to determine an individual's eligibility for such services and if the individual is so eligible, the specific home and community-based services that the individual will receive.

(2) Definition of individual's representative

In this section, the term ''individual's representative'' means, with respect to an individual, a parent, a family member, or a guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) Nonapplication

A State may elect in the State plan amendment approved under this section to not comply with the requirements of section 1396a(a)(10)(B) of this title (relating to comparability) and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community), but only for purposes of provided home and community-based services in accordance with such amendment. Any such election shall not be construed to apply to the provision of services to an individual receiving medical assistance in an institutionalized setting as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded.

(4) No effect on other waiver authority

Nothing in this subsection shall be construed as affecting the option of a State to offer home and community-based services under a waiver under subsections (c) or (d) of this section or under section 1315 of this title.

(5) Continuation of Federal financial participation for medical assistance provided to individuals as of effective date of State plan amendment

Notwithstanding paragraph (1)(B), Federal financial participation shall continue to be available for an individual who is receiving medical assistance in an institutionalized setting, or home and community-based services provided under a waiver under this section or section 1315 of this title that is in effect as of the effective date of the State plan amendment submitted under this subsection, as a result of a determination that the individual requires the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, without regard to whether such individuals satisfy the more stringent eligibility criteria established under that paragraph, until such time as the

individual is discharged from the institution or waiver program or no longer requires such level of care.

(6) State option to provide home and community-based services to individuals eligible for services under a waiver

(A) In general

A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1315 of this title to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title.

(B) Application of same requirements for individuals satisfying needs-based criteria

Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

(C) Authority to offer different type, amount, duration, or scope of home and community-based services

A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

(7) State option to offer home and community-based services to specific, targeted populations

(A) In general

A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

(B) 5-year term

(i) In general

An election by a State under this paragraph shall be for a period of 5 years.

(ii) Phase-in of services and eligibility permitted during initial 5-year period

A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

(C) Renewal

An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning[1] of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.

(j) Optional choice of self-directed personal assistance services

(1) A State may provide, as ''medical assistance'', payment for part or all of the cost of self-directed personal assistance services (other than room and board) under the plan which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under the plan, or home and community-based services provided pursuant to a waiver under subsection (c). Self-directed personal assistance services may not be provided under this subsection to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

(2) The Secretary shall not grant approval for a State self-directed personal assistance services program under this section unless the State provides assurances satisfactory to the Secretary of the following:

(A) Necessary safeguards have been taken to protect the health and welfare of individuals provided services under the program, and to assure financial accountability for funds expended with respect to such services.

(B) The State will provide, with respect to individuals who—

(i) are entitled to medical assistance for personal care services under the plan, or receive home and community-based services under a waiver granted under subsection (c);

(ii) may require self-directed personal assistance services; and

(iii) may be eligible for self-directed personal assistance services,

an evaluation of the need for personal care under the plan, or personal services under a waiver granted under subsection (c).

(C) Such individuals who are determined to be likely to require personal care under the

[1] So in original. Probably should be preceded by ''the''.

plan, or home and community-based services under a waiver granted under subsection (c) are informed of the feasible alternatives, if available under the State's self-directed personal assistance services program, at the choice of such individuals, to the provision of personal care services under the plan, or personal assistance services under a waiver granted under subsection (c).

(D) The State will provide for a support system that ensures participants in the self-directed personal assistance services program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

(E) The State will provide to the Secretary an annual report on the number of individuals served and total expenditures on their behalf in the aggregate. The State shall also provide an evaluation of overall impact on the health and welfare of participating individuals compared to non-participants every three years.

(3) A State may provide self-directed personal assistance services under the State plan without regard to the requirements of section 1396a(a)(1) of this title and may limit the population eligible to receive these services and limit the number of persons served without regard to section 1396a(a)(10)(B) of this title.

(4)(A) For purposes of this subsection, the term ''self-directed personal assistance services'' means personal care and related services, or home and community-based services otherwise available under the plan under this subchapter or subsection (c), that are provided to an eligible participant under a self-directed personal assistance services program under this section, under which individuals, within an approved self-directed services plan and budget, purchase personal assistance and related services, and permits participants to hire, fire, supervise, and manage the individuals providing such services.

(B) At the election of the State—

(i) a participant may choose to use any individual capable of providing the assigned tasks including legally liable relatives as paid providers of the services; and

(ii) the individual may use the individual's budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(5) For purpose of this section, the term ''approved self-directed services plan and budget'' means, with respect to a participant, the establishment of a plan and budget for the provision of self-directed personal assistance services, consistent with the following requirements:

(A) Self-direction

The participant (or in the case of a participant who is a minor child, the participant's parent or guardian, or in the case of an incapacitated adult, another individual recognized by State law to act on behalf of the participant) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider, and location of service provision.

(B) Assessment of needs

There is an assessment of the needs, strengths, and preferences of the participants for such services.

(C) Service plan

A plan for such services (and supports for such services) for the participant has been developed and approved by the State based on such assessment through a person-centered process that—

(i) builds upon the participant's capacity to engage in activities that promote community life and that respects the participant's preferences, choices, and abilities; and

(ii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

(D) Service budget

A budget for such services and supports for the participant has been developed and approved by the State based on such assessment and plan and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

(E) Application of quality assurance and risk management

There are appropriate quality assurance and risk management techniques used in establishing and implementing such plan and budget that recognize the roles and responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan and budget based upon the participant's resources and capabilities.

(6) A State may employ a financial management entity to make payments to providers, track costs, and make reports under the program. Payment for the activities of the financial management entity shall be at the administrative rate established in section 1396b(a) of this title.

(k) State plan option to provide home and community-based attendant services and supports

(1) In general

Subject to the succeeding provisions of this subsection, beginning October 1, 2011, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) or, if greater, the in-

come level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

(A) Availability

The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

(iv) the furnishing of which—

(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of who may act as the employer of record; and

(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

(B) Included services and supports

In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

(iii) voluntary training on how to select, manage, and dismiss attendants.

(C) Excluded services and supports

Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

(i) room and board costs for the individual;

(ii) special education and related services provided under the Individuals with Disabilities Education Act [20 U.S.C. 1400 et seq.] and vocational rehabilitation services provided under the Rehabilitation Act of 1973 [29 U.S.C. 701 et seq.];

(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

(iv) medical supplies and equipment; or

(v) home modifications.

(D) Permissible services and supports

The home and community-based attendant services and supports may include—

(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(2) Increased Federal financial participation

For purposes of payments to a State under section 1396b(a)(1) of this title, with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under section 1396d(b) of this title) shall be increased by 6 percentage points.

(3) State requirements

In order for a State plan amendment to be approved under this subsection, the State shall—

(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability,

or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1396d(a) of this title, this section, section 1315 of this title, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community-based attendant services and supports that—

(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

(4) Compliance with certain laws

A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 [29 U.S.C. 201 et seq.] and applicable Federal and State laws regarding—

(A) withholding and payment of Federal and State income and payroll taxes;

(B) the provision of unemployment and workers compensation insurance;

(C) maintenance of general liability insurance; and

(D) occupational health and safety.

(5) Evaluation, data collection, and report to Congress

(A) Evaluation

The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emotional health of the individuals who receive such services; and an[2] comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

(B) Data collection

The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

(ii) The number of individuals that received such services and supports during the preceding fiscal year.

(iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status.

(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

(C) Reports

Not later than—

(i) December 31, 2013, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

(6) Definitions

In this subsection:

(A) Activities of daily living

The term ''activities of daily living'' includes tasks such as eating, toileting,

[2] So in original. Probably should be ''a''.

grooming, dressing, bathing, and transferring.

(B) Consumer controlled

The term ''consumer controlled'' means a method of selecting and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

(C) Delivery models

(i) Agency-provider model

The term ''agency-provider model'' means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

(ii) Other models

The term ''other models'' means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

(D) Health-related tasks

The term ''health-related tasks'' means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

(E) Individual's representative

The term ''individual's representative'' means a parent, family member, guardian, advocate, or other authorized representative of an individual[3]

(F) Instrumental activities of daily living

The term ''instrumental activities of daily living'' includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

(Aug. 14, 1935, ch. 531, title XIX, §1915, as added Pub. L. 97–35, title XXI, §2175(b), Aug. 13, 1981, 95 Stat. 809; amended Pub. L. 97–35, title XXI, §§2176, 2177(a), Aug. 13, 1981, 95 Stat. 812, 813; Pub. L. 97–248, title I, §137(b)(19)(A), (20)–(25), Sept. 3, 1982, 96 Stat. 380; Pub. L. 97–448, title III, §309(b)(17), Jan. 12, 1983, 96 Stat. 2409; Pub. L. 98–369, div. B, title III, §2373(b)(21), July 18, 1984, 98 Stat. 1112; Pub. L. 99–272, title IX, §§9502(a)–(e), (g)–(i), 9508(a), Apr. 7, 1986, 100 Stat. 202–204, 210; Pub. L. 99–509, title IX, §§9320(h)(3), 9411(a)–(d), Oct. 21, 1986, 100 Stat. 2016, 2061, 2062; Pub. L. 100–93, §8(h)(2), Aug. 18, 1987, 101 Stat. 694; Pub. L. 100–203, title IV, §§4072(d), 4102(a)(1), (b)(2), 4118(a)(1), (b), (i)(1), (k), (*l*)(1), (p)(10), 4211(h)(10), Dec. 22, 1987, 101 Stat. 1330–117, 1330–143, 1330–146, 1330–154 to 1330–157, 1330–160, 1330–206; Pub. L. 100–360, title II, §204(d)(3), title IV, §411(k)(3), (10)(A), (H), (I), (17)(A), (*l*)(3)(G), July 1, 1988, 102 Stat. 729, 791, 794, 796, 799, 803; Pub. L. 100–485, title VI, §608(d)(26)(M), (f)(2), Oct. 13, 1988, 102 Stat. 2422, 2424; Pub. L. 100–647, title VIII, §§8432(a), (b), 8437(a), Nov. 10, 1988, 102 Stat. 3804, 3806; Pub. L. 101–234, title II, §201(a), Dec. 13, 1989, 103 Stat. 1981; Pub. L. 101–239, title VI, §§6115(c), 6411(c)(2), Dec. 19, 1989, 103 Stat. 2219, 2270; Pub. L. 101–508, title IV, §§4604(c), 4704(b)(3), 4741, 4742(a), (c)(1), (d)(1), Nov. 5, 1990, 104 Stat. 1388–169, 1388–172, 1388–197, 1388–198; Pub. L. 102–119, §26(i)(2), Oct. 7, 1991, 105 Stat. 607; Pub. L. 103–66, title XIII, §13603(d), Aug. 10, 1993, 107 Stat. 620; Pub. L. 105–33, title IV, §§4106(c), 4743(a), Aug. 5, 1997, 111 Stat. 368, 524; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(*o*), (z)], Nov. 29, 1999, 113 Stat. 1536, 1501A–397, 1501A–398; Pub. L. 106–554, §1(a)(6) [title VII, §702(c)(2)], Dec. 21, 2000, 114 Stat. 2763, 2763A–574; Pub. L. 107–121, §2(b)(3), Jan. 15, 2002, 115 Stat. 2384; Pub. L. 108–446, title III, §305(j)(2), Dec. 3, 2004, 118 Stat. 2806; Pub. L. 109–171, title VI, §§6052(a), 6086(a), 6087(a), Feb. 8, 2006, 120 Stat. 93, 121, 127; Pub. L. 111–148, title II, §§2401, 2402(b), (c), (e), (f), 2601(a), (b)(1), Mar. 23, 2010, 124 Stat. 297, 302–304, 314, 315; Pub. L. 111–152, title I, §1205, Mar. 30, 2010, 124 Stat. 1056.)

[3] So in original. Probably should be followed by a period.

REFERENCES IN TEXT

The Public Health Service Act, referred to in subsec. (g)(5), is act July 1, 1944, ch. 373, 58 Stat. 682. Title XXVI of the Act is classified generally to subchapter XXIV (§300ff et seq.) of chapter 6A of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 7702B(c)(2)(B) of the Internal Revenue Code of 1986, referred to in subsec. (i)(1)(D)(i), (F)(i), is classified to section 7702B(c)(2)(B) of Title 26, Internal Revenue Code.

The Individuals with Disabilities Education Act, referred to in subsec. (k)(1)(C)(ii), is title VI of Pub. L. 91–230, Apr. 13, 1970, 84 Stat. 175, which is classified generally to chapter 33 (§1400 et seq.) of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

The Rehabilitation Act of 1973, referred to in subsec. (k)(1)(C)(ii), is Pub. L. 93–112, Sept. 26, 1973, 87 Stat. 355, which is classified generally to chapter 16 (§701 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

The Fair Labor Standards Act of 1938, referred to in subsec. (k)(4), is act June 25, 1938, ch. 676, 52 Stat. 1060, which is classified generally to chapter 8 (§201 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see section 201 of Title 29 and Tables.

AMENDMENTS

2010—Subsec. (b). Pub. L. 111–148, §2601(b)(1)(A), inserted at end of concluding provisions ''Subsection (h)(2) shall apply to a waiver under this subsection.''

Subsec. (c)(3). Pub. L. 111–148, §2601(b)(1)(B), inserted ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection''.

Subsec. (d)(3). Pub. L. 111–148, §2601(b)(1)(C), which directed insertion of ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection'' in second sentence, was executed by making the insertion after ''a waiver under this subsection'', to reflect the probable intent of Congress.

Subsec. (h). Pub. L. 111–148, § 2601(a), designated existing provisions as par. (1), inserted '', or a waiver described in paragraph (2)'' after ''(c), (d), or (e)'', and added par. (2).

Subsec. (i)(1). Pub. L. 111–148, § 2402(c), struck out ''or such other services requested by the State as the Secretary may approve'' after ''room and board''.

Subsec. (i)(1)(C). Pub. L. 111–148, § 2402(e)(1), added subpar. (C) and struck out former subpar. (C) which related to projection of number of individuals to be provided home and community-based services and State authority to limit number of eligible individuals.

Subsec. (i)(1)(D)(ii)(II). Pub. L. 111–148, § 2402(e)(2), substituted ''to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria'' for ''to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services''.

Subsec. (i)(3). Pub. L. 111–148, § 2402(f), substituted ''1396a(a)(10)(B) of this title (relating to comparability)'' for ''1396a(a)(1) of this title (relating to statewideness)''.

Subsec. (i)(6), (7). Pub. L. 111–148, § 2402(b), added pars. (6) and (7).

Subsec. (k). Pub. L. 111–148, § 2401, added subsec. (k).

Subsec. (k)(1). Pub. L. 111–152 substituted ''October 1, 2011'' for ''October 1, 2010'' in introductory provisions.

2006—Subsec. (g)(2) to (5). Pub. L. 109–171, § 6052(a), added pars. (2) to (5) and struck out former par. (2), which read as follows: ''For purposes of this subsection, the term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.''

Subsec. (i). Pub. L. 109–171, § 6086(a), added subsec. (i).

Subsec. (j). Pub. L. 109–171, § 6087(a), added subsec. (j).

2004—Subsec. (c)(5)(C)(i). Pub. L. 108–446, which directed the substitution of ''(as such terms are defined in section 1401 of title 20)'' for ''as defined in section 1401(16) and (17) of title 20)'', was executed by making the substitution for ''(as defined in paragraphs (16) and (17) of section 1401(a) of title 20)'' to reflect the probable intent of Congress and the amendment by Pub. L. 102–119. See 1991 Amendment note below.

2002—Subsec. (b). Pub. L. 107–121 substituted ''1396a(bb)'' for ''1396a(aa)''.

2000—Subsec. (b). Pub. L. 106–554 substituted ''1396a(a)(15), 1396a(aa),'' for ''1396a(a)(13)(C)'' in introductory provisions.

1999—Subsec. (b). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(z)], which directed, effective Oct. 1, 2004, substitution of ''section'' for ''sections 1396a(a)(13)(C) and'' in introductory provisions, could not be executed due to the amendment by Pub. L. 106–554. See 2000 Amendment note above.

Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(*o*)(1)], substituted ''1396a(a)(13)(C)'' for ''1396a(a)(13)(E)'' in introductory provisions.

Subsec. (d)(5)(B)(iii). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(*o*)(2)], which directed substitution of ''65'' for ''75'' in last sentence of cl. (iii), was executed by making the substitution in the penultimate sentence to reflect the probable intent of Congress.

Subsec. (h). Pub. L. 106–113, § 1000(a)(6) [title VI, § 608(*o*)(3)], substituted ''90 days of such date'' for ''90 day of such date''.

1997—Subsec. (a)(1)(B)(ii)(I). Pub. L. 105–33, § 4106(c), substituted ''paragraphs (16) and (17)'' for ''paragraphs (15) and (16)''.

Subsec. (c)(5). Pub. L. 105–33, § 4743(a), in introductory provisions, struck out '', with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded'' after '' 'habilitation services' ''.

1993—Subsec. (g)(1). Pub. L. 103–66 inserted ''or to individuals described in section 1396a(z)(1)(A) of this title'' after ''or with either,''.

1991—Subsec. (c)(5)(C)(i). Pub. L. 102–119 substituted ''(as defined in paragraphs (16) and (17) of section 1401(a) of title 20)'' for ''(as defined in section 1401(16) and (17) of title 20)''. The reference to section 1401 of title 20 includes the substitution of ''Individuals with Disabilities Education Act'' for ''Education of the Handicapped Act'' in the original.

1990—Subsec. (b). Pub. L. 101–508, § 4704(b)(3), inserted ''(other than sections 1396a(a)(13)(E) and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title)'' after ''section 1396a of this title'' in introductory provisions.

Pub. L. 101–508, § 4604(c), which directed amendment of subsec. (b) by inserting ''(other than subsection (s))'' after ''Section 1396a of this title'', was executed by inserting the new language after ''section 1396a of this title'' to reflect the probable intent of Congress.

Subsec. (b)(4). Pub. L. 101–508, § 4742(a), inserted before period at end ''and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under section 1396a(a)(37)(A) of this title''.

Subsec. (c)(1). Pub. L. 101–508, § 4741(a), inserted at end ''For purposes of this subsection, the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.''

Subsec. (c)(4). Pub. L. 101–508, § 4742(d)(1), inserted at end ''Except as provided under paragraph (2)(D), the Secretary may not restrict the number of hours or days of respite care in any period which a State may provide under a waiver under this subsection.''

Subsec. (c)(7)(C). Pub. L. 101–508, § 4742(c)(1), added subpar. (C).

Subsec. (d)(1). Pub. L. 101–508, § 4741(a), inserted at end ''For purposes of this subsection, the term 'room and board' shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.''

Subsec. (d)(5)(B)(iv). Pub. L. 101–508, § 4741(b), substituted ''this subchapter whose provisions become effective on or after such date'' for first reference to ''this subchapter''.

1989—Subsec. (a)(1)(B)(ii)(I). Pub. L. 101–239, § 6115(c), substituted ''paragraphs (15) and (16)'' for ''paragraphs (14) and (15)''.

Pub. L. 101–234 repealed Pub. L. 100–360, § 204(d)(3), and provided that the provisions of law amended or repealed by such section are restored or revived as if such section had not been enacted, see 1988 Amendment note below.

Subsec. (b)(4). Pub. L. 101–239, § 6411(c)(2), inserted ''shall be consistent with the requirements of section 1396r–4 of this title and'' after ''which standards''.

1988—Subsec. (a)(1)(B)(ii)(I). Pub. L. 100–360, § 204(d)(3), substituted ''paragraphs (14) and (15)'' for ''paragraphs (13) and (14)''.

Subsec. (a)(2). Pub. L. 100–485, § 608(f)(2), substituted ''restricts'' for ''Restricts'' in introductory provisions.

Subsec. (c)(7). Pub. L. 100–360, § 411(*l*)(3)(G), amended Pub. L. 100–203, § 4211(h)(10)(G), see 1987 Amendment note below.

Subsec. (c)(7)(A). Pub. L. 100–647, § 8437(a), substituted ''who are inpatients in, or who would require the level of care provided in, hospitals,'' for ''who are inpatients in hospitals,'' and ''who are inpatients in, or who would require the level of care provided in, those respective facilities'' for ''who are inpatients of those respective facilities''.

Subsec. (c)(7)(B). Pub. L. 100–360, §411(k)(10)(H), inserted '', without regard to the availability of beds for such inpatients'' before period at end.

Subsec. (c)(10). Pub. L. 100–360, §411(k)(10)(A), substituted ''The Secretary shall not limit to fewer than 200'' for ''No waiver under this subsection shall limit by an amount less than 200'' and ''under a waiver under this subsection'' for ''under such waiver''.

Subsec. (d)(5)(B)(i), (ii). Pub. L. 100–647, §8432(b), in introductory provisions, substituted ''the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year'' for ''the number of years beginning after the base year and ending before the waiver year'', in subcls. (I) and (II), substituted ''between the beginning of the base year and the beginning of the waiver year'' for ''between the base year and the waiver year'', and in subcl. (III), inserted ''(rounded to the nearest quarter of a year)'' after ''for each year'' and substituted ''at the end of the waiver year'' for ''before the waiver year''.

Subsec. (d)(5)(B)(iii). Pub. L. 100–360, §411(k)(3)(A)(ii), inserted before last sentence ''The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period.''

Subsec. (d)(5)(B)(iii)(III). Pub. L. 100–360, §411(k)(3)(A)(i), substituted ''65'' for ''75''.

Subsec. (d)(5)(B)(iv). Pub. L. 100–647, §8432(a), added cl. (iv).

Subsec. (d)(5)(C)(i). Pub. L. 100–360, §411(k)(3)(B), substituted ''paragraph (4), and personal care services'' for ''paragraph (4)(B), personal care services, and services furnished pursuant to a waiver under subsection (c) of this section''.

Subsec. (e). Pub. L. 100–360, §411(k)(17)(A)(ii), (iii), added subsec. (e), redesignated former subsec. (e)(1) as (f)(1), and struck out former subsec. (e)(2) which read as follows: ''The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section.''

Subsec. (f)(1). Pub. L. 100–360, §411(k)(17)(A)(ii), redesignated former subsec. (e)(1) as (f)(1).

Subsec. (f)(2). Pub. L. 100–360, §411(k)(17)(A)(i), redesignated former subsec. (f) as subsec. (f)(2).

Subsec. (h). Pub. L. 100–360, §411(k)(10)(I), made technical amendment to directory language of Pub. L. 100–203, §4118(*l*)(1), see 1987 Amendment note below.

Pub. L. 100–360, §411(k)(17)(A)(iv), as amended by Pub. L. 100–485, §608(d)(26)(M), substituted '', (d), or (e)'' for ''or (d)''.

1987—Subsec. (a)(1)(B)(ii)(I). Pub. L. 100–203, §4072(d), substituted ''paragraphs (13) and (14)'' for ''paragraphs (12) and (13)''.

Subsec. (a)(2). Pub. L. 100–93 amended par. (2) generally. Prior to amendment, par. (2) read as follows: ''restricts—

''(A) for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or

''(B) (through suspension or otherwise) for a reasonable period of time the participation of a provider of items or services under the State plan, if the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the provider has (in a significant number or proportion of cases) provided such items or services either (i) at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), or (ii) of a quality which does not meet professionally recognized standards of health care,

if, under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.''

Subsec. (c)(1). Pub. L. 100–203, §4211(h)(10)(A), substituted ''nursing facility or intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility''.

Subsec. (c)(2)(B). Pub. L. 100–203, §4211(h)(10)(C), in closing provisions, substituted ''need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded'' for ''need for such inpatient hospital, skilled nursing facility or intermediate care facility services''.

Pub. L. 100–203, §4118(p)(10), in closing provisions inserted ''such'' after ''need for''.

Subsec. (c)(2)(B)(i). Pub. L. 100–203, §4211(h)(10)(B), substituted ''services, nursing facility services, or services in an intermediate care facility for the mentally retarded'' for '', skilled nursing facility, or intermediate care facility services''.

Subsec. (c)(2)(C). Pub. L. 100–203, §4211(h)(10)(D), (E), substituted '', nursing facility, or intermediate care facility for the mentally retarded'' for ''or skilled nursing facility or intermediate care facility'' and '', nursing facility services, or services in an intermediate care facility for the mentally retarded'' for ''or skilled nursing facility or intermediate care facility services''.

Subsec. (c)(3). Pub. L. 100–203, §4118(a)(1), substituted '', section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community)'' for ''and section 1396a(a)(10)(B) of this title (relating to comparability)''.

Subsec. (c)(5). Pub. L. 100–203, §4211(h)(10)(F), substituted ''nursing facility or intermediate care facility for the mentally retarded'' for ''skilled nursing facility or intermediate care facility''.

Subsec. (c)(7). Pub. L. 100–203, §4211(h)(10)(G), as amended by Pub. L. 100–360, §411(*l*)(3)(G), substituted '', nursing facilities, or intermediate care facilities for the mentally retarded'' for ''or in skilled nursing or intermediate care facilities'' in subpar. (A) and ''nursing facility'' for ''skilled nursing facility or intermediate care facility'' in subpar. (B).

Pub. L. 100–203, §4118(k), designated existing provisions as subpar. (A) and added subpar. (B).

Subsec. (c)(10). Pub. L. 100–203, §4118(b), added par. (10).

Subsec. (d). Pub. L. 100–203, §4102(a)(1), added subsec. (d). Former subsec. (d) redesignated (h).

Subsec. (g)(1). Pub. L. 100–203, §4118(i)(1), inserted at end ''The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.''

Subsec. (h). Pub. L. 100–203, §4118(*l*)(1), as amended by Pub. L. 100–360, §411(k)(10)(I), substituted '', within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 day of such date, denies such request.'' for ''denies such request in writing within 90 days after the date of its submission to the Secretary.''

Pub. L. 100–203, §4102(b)(2), substituted ''subsection (c) or (d) of this section'' for ''subsection (c) of this section''.

Pub. L. 100–203, §4102(a)(1)(A), redesignated former subsec. (d) as (h).

1986—Subsec. (a)(1)(B)(ii)(I). Pub. L. 99–509, §9320(h)(3), substituted ''paragraphs (12) and (13)'' for ''paragraphs (11) and (12)''.

Subsec. (b). Pub. L. 99–272, §9508(a)(2), inserted provision, following par. (4), that no waiver under this sub-

section may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title.

Subsec. (c)(1). Pub. L. 99–509, §9411(a)(1), inserted ''a hospital or'' after ''level of care provided in'', and struck out provision added by Pub. L. 99–272, §9502(b)(1).

Pub. L. 99–272, §9502(b)(1), inserted provision relating to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would continue to receive inpatient hospital services, skilled nursing facility services, or intermediate care facility services because they are dependent on ventilator support the cost of which is reimbursed under the State plan.

Subsec. (c)(2)(B). Pub. L. 99–509, §9411(a)(2), substituted ''inpatient hospital, skilled nursing facility, or'' for ''skilled nursing facility or'' in cl. (i) and inserted ''inpatient hospital,'' after ''need for'' in concluding provision following cl. (iii).

Subsec. (c)(2)(C). Pub. L. 99–272, §9502(b)(2), inserted ''hospital or'' after ''provided in a'', and ''inpatient hospital services or'' after ''the provision of''.

Subsec. (c)(2)(D). Pub. L. 99–272, §9502(c)(1), inserted ''100 percent of'' after ''does not exceed''.

Subsec. (c)(3). Pub. L. 99–509, §9411(c), substituted ''and section 1396a(a)(10)(B) of this title (relating to comparability)'' for ''and section 1396a(a)(10) of this title''.

Pub. L. 99–272, §9502(g), substituted ''additional five-year periods'' for ''additional three-year periods'', and ''previous waiver period'' for ''previous three-year period''.

Pub. L. 99–272, §9502(e), inserted at end ''A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.''

Subsec. (c)(4)(B). Pub. L. 99–509, §9411(d), inserted before the period ''and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness''.

Subsec. (c)(5). Pub. L. 99–272, §9502(a), added par. (5).

Subsec. (c)(6). Pub. L. 99–272, §9502(c)(2), added par. (6).

Subsec. (c)(7). Pub. L. 99–509, §9411(a)(3), amended par. (7) generally. Prior to amendment, par. (7) read as follows: ''In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditure for other individuals who are inpatients of those facilities.''

Pub. L. 99–272, §9502(d), added par. (7).

Subsec. (c)(8). Pub. L. 99–272, §9502(h), added par. (8).

Subsec. (c)(9). Pub. L. 99–272, §9502(i), added par. (9).

Subsec. (g). Pub. L. 99–272, §9508(a)(1), added subsec. (g).

Subsec. (g)(1). Pub. L. 99–509, §9411(b), inserted provision at end allowing a State to limit case management services to AIDS victims or to individuals with chronic mental illness.

1984—Subsec. (c)(1). Pub. L. 98–369 substituted ''under this subchapter'' for ''under this part''.

1983—Subsec. (c)(2)(B). Pub. L. 97–448 substituted ''need for such skilled nursing facility or intermediate care facility services'' for ''need for such services'' in provisions following cl. (iii).

1982—Subsec. (b). Pub. L. 97–248, §137(b)(19)(A), struck out ''and section 1396b(m) of this title'' after ''section 1396a of this title''.

Subsec. (b)(1). Pub. L. 97–248, §137(b)(20), inserted ''primary care'' before ''case-management system'', and substituted ''medical care services'' for ''primary care services''.

Subsec. (c)(1). Pub. L. 97–248, §137(b)(21), inserted ''payment for part or all of the cost of'' after ''may include as 'medical assistance' under such plan''.

Subsec. (c)(2)(B). Pub. L. 97–248, §137(b)(22), redesignated existing provisions as cls. (i) and (ii) and added cl. (iii).

Subsec. (c)(3). Pub. L. 97–248, §137(b)(23), substituted ''section 1396a(a)(1) of this title'' for ''subsection (a)(1) of this section'' and ''section 1396a(a)(10) of this title'' for ''subsection (a)(10) of section 1396a of this title''.

Subsec. (c)(4). Pub. L. 97–248, §137(b)(24), substituted ''this subsection'' for ''this section''.

Subsec. (f). Pub. L. 97–248, §137(b)(25), inserted ''approval of'' before ''a proposed State plan''.

1981—Subsecs. (c) to (e). Pub. L. 97–35, §2176, added subsec. (c), redesignated former subsec. (c) as (d) and inserted ''(other than a waiver under subsection (c) of this section)'', and redesignated former subsec. (d) as (e).

Subsec. (f). Pub. L. 97–35, §2177(a), added subsec. (f).

EFFECTIVE DATE OF 2010 AMENDMENT

Amendment by section 2402(b), (c), (e), (f) of Pub. L. 111–148 effective on the first day of the first fiscal year quarter that begins after Mar. 23, 2010, see section 2402(g) of Pub. L. 111–148, set out as an Effective and Termination Dates of 2010 Amendment note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6052(c), Feb. 8, 2006, 120 Stat. 95, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2006.''

Pub. L. 109–171, title VI, §6086(c), Feb. 8, 2006, 120 Stat. 127, provided that: ''The amendments made by subsections (a) and (b) [amending this section] take effect on January 1, 2007, and apply to expenditures for medical assistance for home and community-based services provided in accordance with section 1915(i) of the Social Security Act [subsec. (i) of this section] (as added by subsections (a) and (b) [probably means subsec. (a)]) on or after that date.''

Pub. L. 109–171, title VI, §6087(b), Feb. 8, 2006, 120 Stat. 130, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to services furnished on or after January 1, 2007.''

EFFECTIVE DATE OF 2002 AMENDMENT

Amendment by Pub. L. 107–121 effective as if included in the enactment of section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 as enacted into law by section 1(a)(6) of Pub. L. 106–554, see section 2(c)(2) of Pub. L. 107–121, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by Pub. L. 106–554 effective Jan. 1, 2001, and applicable to services furnished on or after such date, see section 1(a)(6) [title VII, §702(e)] of Pub. L. 106–554, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(z)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398, provided that the amendment made by section 1000(a)(6) [title VI, §608(z)] is effective Oct. 1, 2004.

Amendment by section 1000(a)(6) [title VI, §608*o*] of Pub. L. 106–113 effective Nov. 29, 1999, see section 1000(a)(6) [title VI, §608(bb)] of Pub. L. 106–113, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1997 AMENDMENT

Amendment by section 4106(c) of Pub. L. 105–33 applicable to bone mass measurements performed on or

after July 1, 1998, see section 4106(d) of Pub. L. 105–33, set out as a note under section 1395x of this title.

Section 4743(b) of Pub. L. 105–33 provided that: ''The amendment made by subsection (a) [amending this section] apply to services furnished on or after October 1, 1997.''

EFFECTIVE DATE OF 1993 AMENDMENT

Amendment by Pub. L. 103–66 applicable to medical assistance furnished on or after Jan. 1, 1994, without regard to whether or not final regulations to carry out the amendments by section 13603 of Pub. L. 103–66 have been promulgated by such date, see section 13603(f) of Pub. L. 103–66, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1990 AMENDMENTS

Amendment by section 4604(c) of Pub. L. 101–508 effective with respect to payments under this subchapter for calendar quarters beginning on or after July 1, 1991, without regard to whether or not final regulations to carry out the amendments by section 4604 of Pub. L. 101–508 have been promulgated by such date, see section 4604(d) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Amendment by section 4704(b)(3) of Pub. L. 101–508 effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1989, Pub. L. 101–239, see section 4704(f) of Pub. L. 101–508, set out as a note under section 1396a of this title.

Section 4742(b) of Pub. L. 101–508 provided that: ''The amendment made by subsection (a) [amending this section] shall take effect as of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act [Nov. 5, 1990].''

Section 4742(c)(2) of Pub. L. 101–508 provided that: ''The amendment made by paragraph (1) [amending this section] shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35], but shall only apply to facilities the participation of which under a State plan under title XIX of the Social Security Act [this subchapter] is terminated on or after the date of the enactment of this Act [Nov. 5, 1990].''

Section 4742(d)(2) of Pub. L. 101–508 provided that: ''The amendment made by paragraph (1) [amending this section] shall apply as if included in the enactment of the Omnibus Budget Reconciliation Act of 1981 [Pub. L. 97–35].''

EFFECTIVE DATE OF 1989 AMENDMENTS

Amendment by section 6115(c) of Pub. L. 101–239 applicable to screening pap smears performed on or after July 1, 1990, see section 6115(d) of Pub. L. 101–239, set out as a note under section 1395x of this title.

Section 6411(c)(4) of Pub. L. 101–239 provided that: ''The amendment made by paragraph (2) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987 [Pub. L. 100–203].''

Amendment by Pub. L. 101–234 effective Jan. 1, 1990, see section 201(c) of Pub. L. 101–234, set out as a note under section 1320a–7a of this title.

EFFECTIVE DATE OF 1988 AMENDMENTS

Section 8432(c) of Pub. L. 100–647 provided that: ''The amendments made by this section [amending this section] shall apply to waiver years beginning during or after fiscal year 1989.''

Section 8437(b) of Pub. L. 100–647 provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to waiver applications submitted before, on, or after the date of the enactment of this Act [Nov. 10, 1988].''

Amendment by section 608(d)(26)(M) of Pub. L. 100–485 effective as if included in the enactment of the Medicare Catastrophic Coverage Act of 1988, Pub. L. 100–360, see section 608(g)(1) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 608(f)(2) of Pub. L. 100–485 effective Oct. 13, 1988, see section 608(g)(2) of Pub. L. 100–485, set out as a note under section 704 of this title.

Amendment by section 204(d)(3) of Pub. L. 100–360 applicable to screening mammography performed on or after Jan. 1, 1990, see section 204(e) of Pub. L. 100–360, set out as a note under section 1395m of this title.

Except as specifically provided in section 411 of Pub. L. 100–360, amendment by section 411(k)(3), (10)(A), (H), (I), (17)(A), (*l*)(3)(G) of Pub. L. 100–360, as it relates to a provision in the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100–203, effective as if included in the enactment of that provision in Pub. L. 100–203, see section 411(a) of Pub. L. 100–360, set out as a Reference to OBRA; Effective Date note under section 106 of Title 1, General Provisions.

EFFECTIVE DATE OF 1987 AMENDMENTS

For effective date of amendment by section 4072(d) of Pub. L. 100–203, see section 4072(e) of Pub. L. 100–203, set out as a note under section 1395x of this title.

Section 4102(a)(2) of Pub. L. 100–203 provided that: ''The amendments made by paragraph (1) [amending this section] shall become effective on January 1, 1988.''

Section 4118(a)(2) of Pub. L. 100–203 provided that: ''The amendment made by paragraph (1) [amending this section] shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 [Pub. L. 99–509].''

Section 4118(i)(2) of Pub. L. 100–203 provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect as though it were included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99–272].''

Section 4118(*l*)(2) of Pub. L. 100–203 provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to requests for continuation of waivers received after the date of the enactment of this Act [Dec. 22, 1987].''

Section 4118(p)(10) of Pub. L. 100–203 provided that the amendment made by that section is effective as if included in the enactment of Pub. L. 99–509.

Amendment by section 4211(h)(10) of Pub. L. 100–203 applicable to nursing facility services furnished on or after Oct. 1, 1990, without regard to whether regulations implementing such amendment are promulgated by such date, except as otherwise specifically provided in section 1396r of this title, with transitional rule, see section 4214(a), (b)(2) of Pub. L. 100–203, as amended, set out as an Effective Date note under section 1396r of this title.

Amendment by Pub. L. 100–93 effective at end of fourteen-day period beginning Aug. 18, 1987, and inapplicable to administrative proceedings commenced before end of such period, see section 15(a) of Pub. L. 100–93, set out as a note under section 1320a–7 of this title.

EFFECTIVE DATE OF 1986 AMENDMENTS

Amendment by section 9320(h)(3) of Pub. L. 99–509 applicable to services furnished on or after Jan. 1, 1989, with exceptions for hospitals located in rural areas which meet certain requirements related to certified registered nurse anesthetists, see section 9320(i), (k) of Pub. L. 99–509, as amended, set out as notes under section 1395k of this title.

Section 9411(e) of Pub. L. 99–509 provided that: ''The amendments made by this section [amending this section] shall apply to applications for waivers (or renewals thereof) approved on or after the date of the enactment of this Act [Oct. 21, 1986].''

Section 9502(j) of Pub. L. 99–272, as amended by Pub. L. 99–509, title IX, § 9435(a), Oct. 21, 1986, 100 Stat. 2069; Pub. L. 100–203, title IV, § 4118(j), Dec. 22, 1987, 101 Stat. 1330–156, provided that:

''(1) HABILITATION SERVICES.—The amendment made by subsection (a) [amending this section] shall be effective for services furnished on or after the date of the enactment of this Act [Apr. 7, 1986] to individuals eligible for services under a waiver granted under section

1915(c) of the Social Security Act [subsec. (c) of this section], without regard to whether such individuals were receiving institutional services before their participation in the waiver.

''(2) HOSPITALIZED PATIENTS.—The amendments made by subsection (b) [amending this section] shall be effective for services furnished on or after October 1, 1985.

''(3) PROHIBITION OF REGULATORY LIMITS AND TREATMENT OF CERTAIN PHYSICALLY DISABLED INDIVIDUALS.—The amendments made by subsections (c) and (d) [amending this section] shall apply to applications for waivers (or renewals thereof) filed before, on, or after, the date of the enactment of this Act [Apr. 7, 1986] and for services furnished on or after August 13, 1981.

''(4) INCOME STANDARDS.—The amendment made by subsection (e) [amending this section] shall apply to waivers (or renewals thereof) approved before, on, or after the date of the enactment of this Act [Apr. 7, 1986].

''(5) WAIVER EXTENSIONS.—Subsection (f) [enacting provisions set out below] shall apply to waivers expiring on or after September 30, 1985, and before September 30, 1986.

''(6) WAIVER RENEWALS.—The amendments made by subsection (g) [amending this section] shall become effective on September 30, 1986.

''(7) COORDINATED SERVICES AND SUBSTITUTION OF PARTICIPANTS.—The amendments made by subsections (h) and (i) [amending this section] shall become effective on the date of the enactment of this Act [Apr. 7, 1986].''

Section 9508(b) of Pub. L. 99–272, as amended by Pub. L. 99–509, title IX, § 9435(d)(1), Oct. 21, 1986, 100 Stat. 2070, provided that: ''The amendments made by this section [amending this section] shall apply to services furnished on or after the date of the enactment of this Act [Apr. 7, 1986], without regard to whether or not regulations to carry out the amendments have been promulgated by that date.''

[Section 4118(j) of Pub. L. 100–203 provided that the amendment made by that section to section 9502(j)(1) of Pub. L. 99–272, set out above, is effective as if included in the enactment of section 9502 of Pub. L. 99–272.]

EFFECTIVE DATE OF 1983 AMENDMENT

Amendment by Pub. L. 97–448 effective as if originally included as a part of this section as this section was amended by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248, see section 309(c)(2) of Pub. L. 97–448, set out as a note under section 426–1 of this title.

EFFECTIVE DATE OF 1982 AMENDMENT

Section 137(b)(19)(B) of Pub. L. 97–248 provided that: ''The amendment made by subparagraph (A) [amending this section] shall not apply with respect to any waiver if such waiver was granted, and the arrangement covered by the waiver was in place, prior to August 10, 1982.''

Amendment by section 137(b)(20)–(25) of Pub. L. 97–248 effective as if originally included as part of this section as this section was amended by the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35, see section 137(d)(2) of Pub. L. 97–248, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 1981 AMENDMENT

Section 2177(b) of Pub. L. 97–35 provided that: ''The amendment made by this section [amending this section] shall become effective 90 days after the date of the enactment of this Act [Aug. 13, 1981]''.

REGULATIONS

Pub. L. 109–171, title VI, § 6052(b), Feb. 8, 2006, 120 Stat. 95, provided that: ''The Secretary shall promulgate regulations to carry out the amendment made by subsection (a) [amending this section] which may be effective and final immediately on an interim basis as of the date of publication of the interim final regulation. If the Secretary provides for an interim final regulation, the Secretary shall provide for a period of public comments on such regulation after the date of publication. The Secretary may change or revise such regulation after completion of the period of public comment.''

OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES

Pub. L. 111–148, title II, § 2402(a), Mar. 23, 2010, 124 Stat. 301, provided that: ''The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

''(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports (including such services and supports that are provided under programs other [than] the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

''(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

''(3) improve coordination among, and the regulation of, all providers of such services under federally and State-funded programs in order to—

''(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

''(B) oversee and monitor all service system functions to assure—

''(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

''(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

''(iii) an adequate number of qualified direct care workers to provide self-directed personal assistance services.''

QUALITY OF CARE MEASURES

Pub. L. 109–171, title VI, § 6086(b), Feb. 8, 2006, 120 Stat. 127, provided that:

''(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall consult with consumers, health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction with respect to home and community-based services offered under State Medicaid programs.

''(2) BEST PRACTICES.—The Secretary shall—

''(A) use the indicators and measures developed under paragraph (1) to assess such home and community-based services, the outcomes associated with the receipt of such services (particularly with respect to the health and welfare of the recipient of the services), and the overall system for providing home and community-based services under the Medicaid program under title XIX of the Social Security Act [this subchapter]; and

''(B) make publicly available the best practices identified through such assessment and a comparative analyses of the system features of each State.

''(3) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, $1,000,000 for the period of fiscal years 2006 through 2010 to carry out this subsection.''

PERMITTING ADJUSTMENT IN ESTIMATES TO TAKE INTO ACCOUNT PREADMISSION SCREENING REQUIREMENT

Section 4742(e) of Pub. L. 101–508 provided that: ''In the case of a waiver under section 1915(c) of the Social

Security Act [subsec. (c) of this section] for individuals with mental retardation or a related condition in a State, the Secretary of Health and Human Services shall permit the State to adjust the estimate of average per capita expenditures submitted under paragraph (2)(D) of such section, with respect to such expenditures made on or after January 1, 1989, to take into account increases in expenditures for, or utilization of, intermediate care facilities for the mentally retarded resulting from implementation of section 1919(e)(7)(A) of such Act [section 1396r(e)(7)(A) of this title].''

EXTENSIONS OF WAIVERS UNDER SUBSECTION (c)

Section 4102(c) of Pub. L. 100–203 provided that: ''In the case of a State which, as of December 1, 1987, has a waiver approved with respect to elderly individuals under section 1915(c) of the Social Security Act [subsec. (c) of this section], which waiver is scheduled to expire before July 1, 1988, if the State notifies the Secretary of Health and Human Services of the State's intention to file an application for a waiver under section 1915(d) of such Act (as amended by subsection (a) of this section), the Secretary shall extend approval of the State's waiver, under section 1915(c) of such Act, on the same terms and conditions through September 30, 1988.''

Section 9502(f) of Pub. L. 99–272 provided that: ''The Secretary of Health and Human Services shall extend, upon request of the State, any waiver under section 1915(c) of the Social Security Act [subsec. (c) of this section] which expires on or after September 30, 1985, and before September 30, 1986. Such extension shall be for a period of not less than one year nor more than five years, subject to section 1915(e)(1) of such Act.''

§ 1396*o*. Use of enrollment fees, premiums, deductions, cost sharing, and similar charges

(a) Imposition of certain charges under plan in case of individuals described in section 1396a(a)(10)(A) or (E)

Subject to subsections (g), (i), and (j) of this section, the State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i) of section 1396a(a)(10) of this title who are eligible under the plan—

(1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c) of this section);

(2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the Guideline referred to in section 1396d(bb)(2)(A) of this title (or, at the option of the State, any services furnished to pregnant women),

(C) services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs,

(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1396d(a)(4)(C) of this title, or

(E) services furnished to an individual who is receiving hospice care (as defined in section 1396d(*o*) of this title); and

(3) any deduction, cost sharing, or similar charge imposed under the plan with respect to other such individuals or other care and services will be nominal in amount (as determined by the Secretary in regulations which shall, if the definition of ''nominal'' under the regulations in effect on July 1, 1982 is changed, take into account the level of cash assistance provided in such State and such other criteria as the Secretary determines to be appropriate); except that a deduction, cost-sharing, or similar charge of up to twice the nominal amount established for outpatient services may be imposed by a State under a waiver granted by the Secretary for services received at a hospital emergency room if the services are not emergency services (referred to in paragraph (2)(D)) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services.

(b) Imposition of certain charges under plan in case of individuals other than those described in section 1396a(a)(10)(A) or (E)

The State plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section 1396a(a)(10) of this title who are eligible under the plan—

(1) there may be imposed an enrollment fee, premium, or similar charge, which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income,

(2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to—

(A) services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over),

(B) services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1396d(bb) of this title) and covered outpatient drugs (as defined in subsection (k)(2) of section 1396r–8 of this title and including nonprescription drugs described in subsection (d)(2) of such section) that are